PRINTED: FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				(OMB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DA7	ΓΕ SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155752	B. WIN			09/15	5/2011
		<u> </u>	P: (VII)		ADDRESS, CITY, STATE, ZIP CODE	_	
NAME OF	PROVIDER OR SUPPLIER	₹	18325 BAILEY AVE				
MORNI	NGSIDE NURSING A	AND MEMORY CARE CENTER			I BEND, IN46637		
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	r a Recertification and	FC	0000			+
	1		[0000			
	State Licensure Survey.						
	G 1-4 04	/12 0/14 0/15 2011					
	Survey dates: 9/	/13, 9/14, 9/15, 2011					
	Facility number:	004732					
	Provider number						
	1						
	AIM number:	200808300					
	Survey team:						
	1 -	DN TC					
	Vicki Manuwal,						
	Bobbie Costigan						
	Sandra Haws, R	N					
	Census bed type						
	SNF: 3	•					
	NF: 24						
	1	12					
	Total: 39	12					
	101.1. 39						
	Census payor typ	ne·					
	Medicare: 3	ρο.					
	Medicaid: 24						
	Other: 12						
	Total: 39						
	Sample: 10						
	These deficienci	es also reflect state					
	findings cited in	accordance with 410 IAC					
	16.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

10/12/2011

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6DZ911 If continuation sheet 004732 Page 1 of 35

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
ANDILAN	or correction	155752	A. BUILDING	00	09/15/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		l	BAILEY AVE	
		AND MEMORY CARE CENTER		I BEND, IN46637	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG		/22/11 by Suzanne	IAG		DAIL
	Williams, RN	722/11 by Suzainic			
F0157	· · · · · · · · · · · · · · · · · · ·	nediately inform the			
SS=D	-	vith the resident's physician;			
00 5		y the resident's legal			
	representative or an interested family member				
		sccident involving the ults in injury and has the			
		ing physician intervention; a			
		in the resident's physical,			
		social status (i.e., a			
	deterioration in he	alth, mental, or is in either life threatening			
		cal complications); a need to			
		nificantly (i.e., a need to			
		sting form of treatment due			
		juences, or to commence a			
		nent); or a decision to ge the resident from the			
	facility as specified				
		Iso promptly notify the own, the resident's legal			
		nterested family member			
		ange in room or roommate			
		ecified in §483.15(e)(2); or			
	_	ent rights under Federal or			
	paragraph (b)(1)	ations as specified in			
	paragraph (b)(1) (or trio occitori.			
		ecord and periodically			
		s and phone number of the			
	resident's legal representative or interested family member.				
		ew and record review, the	F0157	F157- The facility will inform	10/03/2011
		notify the physician of		physician, family and/or lega	ıl eri
	_	Its that fell within call		representative when blood s	
		of 4 diabetic residents		results are not within parame Resident #26 blood sugars h	
reviewed for diabetic call orders in a			been reviewed and have been		
	sample of 10.	cont out orders in a		found to be within parameter	
	campio or ro.				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155752	B. WIN			09/15/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			18325 E	BAILEY AVE		
MORNIN	GSIDE NURSING A	AND MEMORY CARE CENTER		1	I BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident # 26 Findings include 1. The clinical reviewed on 9/14 indicated diagnost diabetes mellitus dementia. A Physician Orderindicated, "BS than) 400 call Million Review of the Au Monitoring Flow following two blecall parameters: 8/4/11 4:00 P.M. 8/17/11 6:00 P.M. The clinical recordering for the physician notion of the physician notion.	ecord for Resident # 26, 1/11 at 9:50 A.M., ses of, but not limited to: hypertension, and er, dated 3/23/11, (blood sugar)> (greater D" Ingust 2011, "Diabetic Sheet", indicated the ood sugars that fell above Accu Check 408. I. Accu Check 408.			CROSS-REFERENCED TO THE APPROPRIA	fied d blood or et eview coring to e by re no er eted gnee. ew its istent	
		on 9/15/11 at 11:05 ndicated she is aware of					

004732

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	E CON	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	or correction	155752	A. BUILDING		00	09/15/2	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		-
MORNIN	GSIDE NURSING A	ND MEMORY CARE CENTER			AILEY AVE BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	.,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F0223 SS=A	errors related to sphysician notifical A facility policy provided by the IA.M., indicated, accordance with a 3.1-5(a)(2) The resident has the verbal, sexual, physical punishment, or inverbal abuser seclusion. The facility must nesecularly facility failed to a from verbal abuser eviewed for abuse	sliding scale and lack of ation. untitled, undated, DON on 9/15/11 at 11:00 "Notify physician in call orders" the right to be free from ysical, and mental abuse, ent, and involuntary ot use verbal, mental, abuse, corporal voluntary seclusion. ew and record review, the ensure residents were free er for 1 of 10 residents se in a sample of 10.	F0223		The Facility will ensure that a residents are free from verba abuse. The incident was reported to ISDH within 24 hours. CN was suspended immediately then terminated. No other residents were effected by the deficiency. All staff have bee in-serviced on abuse and neepolicy. Administrator and DO designee will monitor staff day ensure that residents are free from any abuse. All investigations will be reviewed DON and Administrator or designee. The results of all investigation regards of resident abuse will reported monthly to QA command Additional plan of correction whe implemented as needed based on the control of th	orted A # 2 and is n glect N or of be ed by as in be nittee. vill	10/03/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155752	B. WIN			09/15/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				BAILEY AVE		
MORNIN	GSIDE NURSING A	AND MEMORY CARE CENTER			I BEND, IN46637		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	An abuse allegat	ion was reported by the			on the results of the investiga		
	facility to Indiana	a State Department of			Administrator and Director of		
	Health on 10/20/11 at 8:58 a.m. The abuse incident occurred on 10/19/10 at 12:30 p.m. and involved CNA # 2 and Resident # 11. The incident report completed by the Director of Nursing indicated "while				Nursing or designee will conti		
					monitor daily the staff to ensu that residents are free from a		
					abuse.	шу	
					acuse.		
		· ·					
	l ` ′	esident (name) on the					
		I am sick and tired of					
		_ ing on yourself.' This					
	was witnessed by	y two other staff					
	members."						
	Dania - an intami	ione midh dha Dinastan a f					
	_	iew with the Director of					
		11 at 10:00 a.m., she					
		A was suspended					
	l -	then terminated because					
		s heard by another staff					
	member. She ind	licated the other staff that					
	heard the comme	ent was the activity staff #					
	3.						
	During an intervi	iew with the activity staff					
	~	10:30 a.m., she indicated					
		d become wet from being					
		e let CNA #2 know the					
		oileted and changed. She					
		she was able to hear the					
		2 made to the resident.					
		indicated she reported					
	I -	-					
		e Director of Nursing					
	immediately.						

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/15/2011
		100702	B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/10/2011
NAME OF	PROVIDER OR SUPPLIER			BAILEY AVE	
MORNIN	IGSIDE NURSING A	ND MEMORY CARE CENTER	SOUTH	I BEND, IN46637	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	A statement reco activity staff # 3 (CNA # 2) (name (Resident # 11) (stated 'I'm sick or on herself.' Ther heard this beside staff # 3. A statement reco # 4 on 10/19/10 is batheroom (sic) and (Resident # 11 of you pi ing of the piece of	rded and signed by the undated indicated "e) got mad because name) was wet. She f her fat a _ pi _ ing e were other people who is me." Signed by activity rded and signed by CNA indicated "I was in the with (CNA # 2) (name) 1) when she said I'm tired on yourself." # 2's employee record on indicated she had on the facility's policy on indicated and neglect on indicated "Abuse deporting Policy" if 11 at 10:00 a.m. in policy of (facility residents and staff from to adequately train I in methods of detection in abuse. (Facility name)	TAG		TE DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155752		A. BUILDING B. WING	00	COMP 09/15/2	LETED	
	PROVIDER OR SUPPLIER	ND MEMORY CARE CENTER	STREET. 18325	ADDRESS, CITY, STATE, ZIP COE BAILEY AVE H BEND, IN46637	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	terms to resident within their hear residents in a neg of their age, abilidisability. Use of resident's present Although the fac and neglect policing the increporting the incresspended, the in ISDH within 24 billions.	paraging and derogatory is or their families, or ing distance, to describe gative manner, regardless ity to comprehend, or a vulgar language in a ce or hearing range" illity followed their abuse by, by staff immediately ident, CNA #2 was acident was reported to thours, an investigated of completed and the riminated.				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, print paric	00	COMPLETED
		155752	A. BUILDING B. WING		09/15/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	₹		BAILEY AVE	
MORNIN	GSIDE NI IRSING A	AND MEMORY CARE CENTER		H BEND, IN46637	
				1 BEND, 11440037	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		not employ individuals who	IAG		DAIL
F0225 SS=D	,	guilty of abusing, neglecting,			
33-0	· · · · · · · · · · · · · · · · · · ·	idents by a court of law; or			
	_	g entered into the State			
	nurse aide registry	y concerning abuse, neglect,			
	mistreatment of residents or misappropriation				
of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged					
		g mistreatment, neglect, or			
		njuries of unknown source			
		tion of resident property are			
		tely to the administrator of			
		other officials in accordance ough established procedures			
		State survey and certification			
	agency).	rate survey and sertification			
	- 5 - 7,				
	The facility must h	nave evidence that all			
	_	are thoroughly investigated,			
		further potential abuse while			
	the investigation is	s in progress.			
	The results of all in	nvestigations must be			
		ministrator or his designated			
		d to other officials in			
		State law (including to the			
		certification agency) within 5			
		ne incident, and if the alleged			
	violation is verified appropriate corrective				
	action must be taken.			F005 TI ('''' '''	
		ew and record review, the	F0225	F225 - The facility will ensu	
	<u>-</u>	ensure injuries of		that injuries of unknown originare investigated thoroughly.	1111
	_	were thoroughly and		Resident # 43 has expired s	ince
	completely inves	stigated and in accordance		incident occurred 7 months	• • • • • • • • • • • • • • • • • • •
	with the facility's	s policy for 1 of 3		Other investigations have be	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPLETEI)
		155752	A. BUII B. WIN			09/15/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		1	BAILEY AVE		
MORNIN	GSIDE NURSING	AND MEMORY CARE CENTER			BEND, IN46637		
					BEND, IN-10007		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	, i	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	MPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·		DATE
		ed for injuries in a sample			reviewed to ensure thorough complete investigations have		
	of 10.				occurred. No new issues no		
	Resident # 43 Findings include:				Staff and Management Team		
					have been in-serviced on inc		
					and accident policy and the		
					necessity to investigate all		
					incidents thoroughly. Report		
	1 The closed cl	inical record for Resident			protocol has been in-service well. All investigations will b		
		n 9/15/11 at 9:20 A.M.,			reviewed by DON or designe		
	I				and Administrator to ensure	.	
		ses of, but not limited to:			continued thoroughness in		
	right ulna fracture, end stage renal				investigation protocol. All		
	disease, and dem	nentia.			incidents will be reviewed an	d	
					reported to QA to continue		
	A facility "Incide	ent/Accident Report,"			monitoring and compliance.		
	indicated, "2/1	3/11 1:45 P.MR (right)			The results of all investigations regards of injuries of unknown		
	wrist edema (sw	elling)Called to RM			origin will be reported monthly		
	(room) by CNA	(certified nursing			QA committee. Additional pl		
	l ` ′ •	resident) up in W/C			correction will be implemente		
	·	(complaining of) R wrist			needed based on the results	of	
	'	ak in skin, 0 bruising			the investigations.		
	*	edema noted to R wrist. 0					
		Res screaming c (with)					
	finger touch to R	C wrist"					
		cility Incident Reporting					
	Form," indicated	l, "Faxed to ISDH					
	(Indiana State D	epartment of					
	Health)2/14/11	@ (at) 12:40					
	P.MResident Time: 2/13/11 @ 1:45 P.MResident complained of R wrist pain, had pain c palpation (touch), edema to wrist, no bruisingStaff being						
	interviewedIn						
	initer vieweuIII	шаг кероп					
			1				

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752		ULTIPLE CO LDING	DNSTRUCTION 00	(X3) DATE: COMPL 09/15/2	ETED
		100702	B. WIN		A DDDDGG GIEW GEATE ZID GODE	09/13/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE		
MORNIN	GSIDE NURSING A	ND MEMORY CARE CENTER			BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		f another "Facility					
		ng Form," undated,					
	indicated, "Faxed to ISDH2/18/11 @ 12:40 P.MStaff Involved (Name) (LPN # 20)Resident c/o R wrist pain on 2/13/11, edema & pain noted. Resident						
		(emergency room). After					
	1	vestigat (sic) & staff					
		A's, CNA on duty 2/13/11					
	on 11 p (P.M.) to 7 a (A.M.) shift stated reside (sic) (Resident # 43) was found on floor next to bed on fall mat & she						
	_	on duty. Right ulnar on duty 2/13/11 for 11 p					
		nded after completion on					
	_	not reporting incident &					
	"	eility policy, & terminated					
		& not following facility					
	policy"						
	Review of a writ	ten statement from LPN					
	# 20, dated 2/13/	11 11:50 P.M., indicated,					
		o pain or discomfort					
	1 *	me by staff or resident					
	`	11 P.M. to 7 A.M.)					
		1. When resident was					
	~	ea in W/C (after) getting					
		only talked of finding bed					
	of discomfort or	bed. There were no signs					
	of disconnion of	paiii.					
	A written stateme	ent from CNA # 17, dated					
	2/13/11, indicated, "(Resident # 43) was						
		ut her arm on 2/12/11.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6DZ911

Facility ID:

004732

If continuation sheet

Page 10 of 35

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE'	
		155752	B. WIN			09/15/20	11
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIER			18325 E	BAILEY AVE		
MORNIN	IGSIDE NURSING A	AND MEMORY CARE CENTER		SOUTH	I BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BETTELENCT)		DATE
		something to it but she					
	I -	ny pain. She just started					
	talking about some men, but she appeared to be fine. She didn't show any sign of pain when we dressed her." Review of a written statement from CNA						
	# 21, dated 2/13/	11, indicated, "					
	(Resident # 43) v	vas complaining of some					
	men doing somet	thing to her but					
	complained of no	pain and wasn't					
	showing any sign	ns of such. She was fine					
	during getup (sic). She just kept saying					
	she was ready to	get out of bed."					
	-						
	A facility "Corre	ctive Action Form," dated					
	2/16/11, indicate	d, "(LPN # 20)Fall					
	being investigate	d that wasn't					
	documented, resu	alted in					
	fracture?Suspe	nded pending					
	investigation 2/1	6. 2/18/11 After					
	completion of in	vestigation Nurse (sic)					
	terminated 2 (sec	condary) (sic) not					
	reporting inciden	t & not following					
	company policies	S"					
	Daniana - Cala - UC	Lillad Daila Name					
		killed Daily Nurses					
	1	"2/13/11 5:45 A.M.					
		(night) s (without) S/S					
	(signs & sympton						
	1 *	f during care (LPN #					
	l '	5 P.M. Called to RM by					
	CNA, family at b	, G					
	(daughter). Res	c/o R wrist pain upon					

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 00	COMPL	ETED
		155752	B. WIN	G		09/15/2	011
	PROVIDER OR SUPPLIER			18325 E	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE		
MORNIN	IGSIDE NURSING A	ND MEMORY CARE CENTER		SOUTH	BEND, IN46637		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	noted to wrist, 0 injury this shift. states she has had day until daugh a room) eval (evalupain2/13/11 8: returnedwith ul (right) wrist splint wrist splint intact discomfort/pain r 20)2/16/11 8:30 S/S discomfort et (sic). R wrist spl swelling to tips or discoloration not Review of Reside (Minimum Data indicated, "Cog determine" A "ER Physician indicated, "preside partment with This was noticed at the extended-cif the patient had although she did agoThe right withere is a deform swelling. It is verification in the swelling. It is verification in the state of the patient had although she did agoThe right withere is a deform swelling. It is verification in the state of the patient had although she did agoThe right withere is a deform swelling. It is verification in the state of the patient had although she did ago	on P.M. Resident nar fractureRes in Rt nt2/14/11 7:15 A.M. R ntNo S/S noted(LPN # O A.M. Rested thru noc s nt (and) no c/o voiced int dry/intactsome of fingers noted. No ed" ent # 43's quarterly MDS Set), dated 8/11/11, quition - unable to Report," dated 2/13/11, sents to the emergency right wrist deformity. by the patient's daughter are facility, it is unclear a recent trauma, have a fall several weeks wrist in the ulnar aspect ity and there is visible rry minimally of the right wrist, there is a					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPI	LETED
		155752	B. WIN			09/15/2	011
VALUE OF PROVIDER OF GURNA HER				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				18325 E	BAILEY AVE		
	MORNINGSIDE NURSING AND MEMORY CARE CENTER		_	SOUTH	BEND, IN46637		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	-	TAG	BEIGE (1)		DATE
	displacement"						
		inical schedule from					
	1 -	ough February 13th, 2011,					
		ale CNA was scheduled					
	for the 3 P.M. to	11 P.M. shift. The					
	Daily Staffing S	Sheet" indicated the CNA					
	did report for the	e scheduled shifts.					
	On 9/14/11 at 4:	00 P.M., the					
	Administrator in	dicated the facility					
	investigates all a	ecidents.					
	Interview with the	ne DON on 9/15/11 at					
	11:05 A.M., she	indicated she checked the					
	· ·	night in question, but					
		A's were working that					
	1 *	er indicated she should					
	~	re thorough investigation					
	of the incident.	e morough investigation					
	of the including						
	On 0/15/11 of 11	:30 A.M., the DON					
		20 lied about the incident					
		iment or report the fall.					
		eated she was more					
		the fall and not the					
	"men" statement						
	During interview	v on 9/15/11 at 11:30					
	~						
		, with the DON present,					
		ard Resident # 43's alarm					
		tated she found Resident					
		mat and immediately					
	reported it to LP	N # 20. She further					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ONSTRUCTION 00	(X3) DATE : COMPL	
		155752	A. BUI. B. WIN	LDING IG		09/15/2	011
NAME OF I	PROVIDER OR SUPPLIER		P. ,, 11.		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					BAILEY AVE		
MORNIN	GSIDE NURSING A	ND MEMORY CARE CENTER		SOUTH	H BEND, IN46637		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		20 told her to not					
		She indicated she did					
	not report the fall	l or LPN # 20's statement					
	to anyone else.						
		5/11 at 12:00 P.M., CNA					
		e heard Resident # 43's					
		and found Resident # 43 floor mat. She indicated					
	• •	is not complaining of					
		r indicated she went and					
	_	PN # 20 and CNA # 17					
	~	lent # 43's room and					
		er bed. She indicated					
	LPN# 20 was che	ecking Resident # 43					
	over. She indica	ted she reported the fall					
	to only LPN # 20), and LPN # 20 said,					
	1	t it. She further indicated					
		tement the next day					
		t didn't not relate the fall					
	_	She indicated LPN # 20					
	1	her to not document the					
	ian out told her o	lon't worry about it.					
	Review of a facil	ity policy titled "Abuse					
		Leporting Policy",					
		d, "Any staff member					
	whohas knowle	edge a resident has					
	sustained a physi	cal injury which is not					
		ined by the history of					
	injuriesis requi						
	immediate oral re	•					
		irector of Nursing, their					
	supervisor and So	ocial Services Director, if					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CON	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	155752	A. BUIL	DING	00	COMPL 09/15/2	
		133732	B. WING		DDDEGG OWN CHATE ZID CODE	03/13/2	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE AILEY AVE		
MORNIN	GSIDE NURSING A	AND MEMORY CARE CENTER			BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	* * *	mplaints of abuse by a					
		e promptly addressed by					
	the nurse on duty						
	-	investigated per protocol					
	to eliminate any	question of abuse"					
	3.1-28(a)						
	3.1-28(d)						
F0226 SS=D	written policies and mistreatment, negliand misappropriation	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property.					
		ew and record review, the	F02	226	F226 - The facility will ensure alleged abuse and injuries of		10/03/2011
	•	implement their written			unknown origin are investiga		
		ng alleged abuse and			thoroughly. Resident # 43 ha		
	injuries of unkno	own origin for 1 of 7			expired since incident occurr		
	residents reviewe	ed for abuse and neglect			months ago. Other investiga		
	in a sample of 10).			have been reviewed to ensur thorough and complete		
	Resident # 43				investigations have occurred new issues noted. Staff and Management Team have bee		
	Findings include	:			in-serviced on abuse and inc and accident policy and the		
		acility policy titled			necessity to investigate all incidents thoroughly. Report		
		on and Reporting Policy",			protocol has been in-serviced well. All investigations will be		
		ed, "Any staff member			reviewed by DON or designe		
		edge a resident has			and Administrator or designe		
		ical injury which is not			ensure continued thoroughne	ess in	
		ined by the history of			investigation protocol. All	d	
	injuriesis requi				incidents will be reviewed an reported to QA to continue	u	
	immediate oral re				monitoring and compliance.		
	•	Pirector of Nursing, their			The results of all investigation	ns in	
	supervisor and Se	ocial Services Director, if			regards of resident abuse and		
					injuries of unknown origin w	ill	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155752	A. BUII		00	09/15/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹		1	BAILEY AVE		
		AND MEMORY CARE CENTER		1	I BEND, IN46637		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
IAU	 	omplaints of abuse by a		IAU	be reported every 3 months to	<u> </u>	DATE
	1	e promptly addressed by			QA committee. Additional pla		
	the nurse on dut				correction will be implemente		
		investigated per protocol			needed based on the results		
	1 *	question of abuse"			investigations. Administrator a Director of Nursing will conti		
		question of doube			to monitor daily the staff to e		
	The closed clinic	cal record for Resident #			that residents are free from a		
		9/15/11 at 9:20 A.M.,			abuse and injuries.		
		ses of, but not limited to:					
	·	re, end stage renal					
	disease, and den						
	A facility "Incid	ent/Accident Report,"					
	indicated, "2/1	3/11 1:45 P.MR (right)					
	wrist edema (sw	elling)Called to RM					
	(room) by CNA	(certified nursing					
	assistant). Res (resident) up in W/C					
	(wheel chair) c/o	o (complaining of) R wrist					
	pain. 0 (no) brea	ak in skin, 0 bruising					
	noted. General	edema noted to R wrist. 0					
		Res screaming c (with)					
	finger touch to F	R wrist"					
	Davies C. UE	ailita. In aid ant Dona arin a					
		cility Incident Reporting					
	(Indiana State D	l, "Faxed to ISDH					
	Health)2/14/11	•					
	· '	Fime: 2/13/11 @ 1:45					
		complained of R wrist					
		palpation (touch), edema					
	1 -	singStaff being					
	interviewedIn	c c					
		ropor					
	Further review of	of another "Facility					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155752	B. WIN			09/15/20	011
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIER			1	BAILEY AVE		
MORNIN	IGSIDE NURSING A	AND MEMORY CARE CENTER		SOUTH	I BEND, IN46637		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	JΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1 -	ng Form," undated,					
	1	ed to ISDH2/18/11 @					
		f Involved (Name) (LPN					
	1 '	c/o R wrist pain on					
		& pain noted. Resident					
		(emergency room). After					
	completion of in	vestigat (sic) & staff					
	interviews c CNA	A's, CNA on duty 2/13/11					
	on 11 p (P.M.) to	7 a (A.M.) shift stated					
	reside (sic) (Resi	dent # 43) was found on					
	floor next to bed	on fall mat & she					
	reported to nurse	on duty. Right ulnar					
	1 -	on duty 2/13/11 for 11 p					
		nded after completion on					
	1 ^	not reporting incident &					
	ı	cility policy, & terminated					
	1	& not following facility					
	policy"	a not ronowing racinty					
	poney						
	Review of a writ	ten statement from LPN					
		11 11:50 P.M., indicated,					
	· ·	o pain or discomfort					
		me by staff or resident					
	1 *	11 P.M. to 7 A.M.)					
	1	1. When resident was					
	ı	ea in W/C (after) getting					
		only talked of finding bed					
	1 ~ ~	bed. There were no signs					
	of discomfort or	paın."					
	A	ant from CNIA // 17 1-1-1					
		ent from CNA # 17, dated					
		d, "(Resident # 43) was					
		ut her arm on 2/12/11.					
	She said men did	something to it but she					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	I DING	00	COMPLETED
		155752	B. WIN			09/15/2011
			D. (111)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			18325 E	BAILEY AVE	
	IGSIDE NURSING A	AND MEMORY CARE CENTER		1	I BEND, IN46637	
(X4) ID				ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	.	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	1	any pain. She just started				
	ı ~	ne men, but she appeared				
		idn't show any sign of				
	pain when we dro	essed her."				
		ten statement from CNA				
	# 21, dated 2/13/	11, indicated, "				
	(Resident # 43) v	was complaining of some				
	men doing some	thing to her but				
	complained of no	pain and wasn't				
	showing any sign	ns of such. She was fine				
). She just kept saying				
	she was ready to					
		8				
	A facility "Corre	ctive Action Form," dated				
	1 *	d, "(LPN # 20)Fall				
	being investigate					
	documented, resi					
	fracture?Suspe					
	1	_				
	investigation 2/1					
	1 *	vestigation Nurse (sic)				
	`	condary) (sic) not				
	l	at & not following				
	company policies	S"				
	On 9/14/11 at 4:0	00 P.M., the				
		dicated the facility				
	investigates all a					
	mvestigates all a	cordents.				
	Interview with th	ne DON on 9/15/11 at				
	11:05 A.M., she	indicated she checked the				
	schedule for the	night in question, but				
	only female CNA	A's were working that				
	1 *	er indicated she should				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION 00	(X3) DATE S COMPL	
		155752	A. BUILD B. WING	ING	<u></u>	09/15/20	011
	PROVIDER OR SUPPLIER	ND MEMORY CARE CENTER		18325 B	DDRESS, CITY, STATE, ZIP CODE BAILEY AVE BEND, IN46637		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE .	(X5) COMPLETION DATE
	have done a more of the incident.	e thorough investigation					
	indicated LPN # and did not document of the further indicated about "men" statement. During interview A.M., CNA # 17, she stated she for floor mat and impurent LPN # 20. She floor mat and impurent indicated she did LPN # 20's stater. Interview on 9/14 # 17 indicated she sitting up on her indicated she were she indicat	20 lied about the incident ment or report the fall. ated she was more the fall and not the on 9/15/11 at 11:30 with the DON present, and Resident # 43 on the mediately reported it to arther indicated LPN # document the fall. She not report the fall or ment to anyone else. 5/11 at 12:00 P.M., CNA e found Resident # 43 floor mat. She further int and got LPN # 20. The reported the fall to only PN # 20 said don't worry ther indicated she wrote enext day about the arm ate the fall to the arm teed LPN # 20 didn't					
	1 ^	not document the fall					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DINC	00	COMPL	ETED
		155752	A. BUII B. WIN			09/15/2	011
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			ı	BAILEY AVE		
MORNIN	GSIDE NURSING A	AND MEMORY CARE CENTER			I BEND, IN46637		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	facility must be pro in accordance with plan of care. Based on intervio	ided or arranged by the byided by qualified persons in each resident's written ew and record review, the ensure physician orders	F0	282	F282 – The facility will follow physician orders. Resident and #40 have had a complet	# 26	10/03/2011
	were followed re	lated to blood sugars and			audit of records to ensure	.0	
	administration of	f insulin coverage for 2 of			compliance with physician		
	4 residents review	wed for diabetes in a			orders. Physician has been		
	sample of 10.				notified of discrepancies ider		
	Resident # 26, # Findings include		during survey. No new orders noted. Other residents with accu-checks have had a review of medical records to verify compliance with physician orders related to blood sugars. No		iew		
	reviewed on 9/14 indicated diagnordiabetes mellitus dementia. A Physician Ordindicated, "Acc test) before meal bedtimeNovoli scaleBS (blood 250=0 units; 251 than) 400=12 units. Review of the Ju Monitoring Flow	n R (insulin)sliding l sugar) < (less than) -400=8 units; > (greater its; > 400 call MD" ne, 2011, "Diabetic Sheet", indicated scale coverage for the			issues identified. Nurses habeen in-serviced on proper protocol after accu-checks. diabetic flow sheets have be implemented to ensure conticompliance. Audits are performed at least daily by Edesignee. Results of audits be reported to QA to ensure continued compliance. Audits will be conducted daily the first 3 months by Director Nursing or designee. The QA committee will review findings determine if audits can be suspended, If consistent complis met for quarter. Than audit will be performed once a weel Director of Nursing or designe	New en nued DON will for of sto iance ts c by	

004732

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE	
THETETAL	or conduction	155752	A. BUII			09/15/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				BAILEY AVE		
MORNIN	GSIDE NURSING A	AND MEMORY CARE CENTER		SOUTH	I BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710		M Accu Check 479. No	+	1710			DATE
		ented; should have					
	"	. Next available Accu					
	Check 6/17/11 12						
		I Accu Check 249.					
	l '	ould have received 0					
		able Accu Check 6/17/11					
	9:00 P.M 402.						
	6/24/11 5:00 P M	I Accu Check 400.					
		hould have received 8					
	l	able Accu Check 6/24/11					
	9:00 P.M 118.						
		I Accu Check 236.					
	· ·	ould have received 0					
	9:00 P.M 161.	able Accu Check 6/28/11					
	9.00 P.M 101.						
	Review of the Ju	ly, 2011, "Diabetic					
	Monitoring Flow	Sheet", indicated					
		scale coverage for the					
	following five A	ccu Checks:					
	7/7/11 0:00 D M	- Accu Check both 372					
	& 317 document						
		uld have received 8					
	· ·	able Accu Check 7/8/11					
	6:00 A.M 92.						
	7/12/11 9:00 P.M	1 Accu Check 316. No					
	_	ented; should have					
	received 8 units.	Next available Accu					

004732

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155752	B. WIN			09/15/2	011
NAME OF PRODUCTION OF GUIDAVIEW				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER			18325 E	BAILEY AVE		
	GSIDE NURSING A	AND MEMORY CARE CENTER		SOUTH	I BEND, IN46637		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Check 7/13/11 6:	:00 A.M 142.					
	7/14/11 6:00 P.M. coverage docume received 8 units. Check 7/14/11 9: 7/15/11 6:00 A.M. Given 8 units; sh units. Next avail 12:00 P.M 242 7/15/11 6:00 P.M. Given 10 units; s units. Next avail 9:00 P.M 216. Review of the Au Monitoring Flow incorrect sliding following Accu Co.	M Accu Check 337. No ented; should have Next available Accu :00 P.M 216. M Accu Check 416. Hould have received 12 lable Accu Check 7/15/11 M Accu Check 400. Should have received 8 lable Accu Check 7/15/11 Ingust, 2011, "Diabetic of Sheet", indicated scale coverage for the Check:					
		M Accu Check 324. cumented; should have					
	_	Next available Accu					
	Check 8/13/11 6:						
	Check 8/13/11 6:	.UU r.IVI 224.					
		are plan, dated 12/23/10, minister insulin & oral dered"					
	9/15/11 at 11:05	with the DON on A.M., she indicated she the multiple sliding scale					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155752		A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPL 09/15/2	ETED	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		18325 E	BAILEY AVE		
MORNIN		AND MEMORY CARE CENTER		SOUTH	BEND, IN46637		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
		ner indicated she checked monitoring tool for					
		it not accuracy of the					
		cause she assumed every					
	nurse should kno	ow how to do sliding					
	scale.						
	2 The clinical r	record for Resident # 40,					
		4/11 at 11:30 A.M.,					
		ses of, but not limited to:					
	diabetes mellitus	s, hyperthyroidism, and					
	peripheral neuro	pathy.					
	A Physician Ord	er, dated 5/27/11,					
	· ·	cu Check (blood sugar					
	test) AC (before	·					
	l ` ′	olin R (insulin)sliding					
	`	d sugar) < (less than) 1-200=2 units; 201-250=4					
	· ·	6 units; 301-350=8 units;					
	· · · · · · · · · · · · · · · · · · ·	ts; > (greater than)					
	400=12 units; ar	nd call MD"					
	Davious of the L	uly 2011 "Diobatia					
		ıly, 2011, "Diabetic v Sheet", indicated					
		scale coverage for the					
	following 11 Ac	_					
		Accu Check 220.					
	· ·	hould have received 4					
	units. Next avai 12:00 P.M 320	lable Accu Check 7/4/11					
	12.001.101 320	J.					
	7/4/11 12:00 P.N	1 Accu Check 320.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155752	B. WIN		- 	09/15/2011
NAME OF PROVIDER OR SUPPLIER			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	BAILEY AVE	
MORNIN	GSIDE NURSING A	AND MEMORY CARE CENTER		SOUTH	I BEND, IN46637	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)	DATE
	-	should have received 8				
		lable Accu Check 7/4/11				
	6:00 P.M 232.					
	7/5/11 10:00 P.N.	A agu Chaola 210				
		1 Accu Check 218.				
	· ·	ould have received 4				
		lable Accu Check 7/5/11				
	6:00 P.M 286.					
	7/0/11 (.00 D M	A any Charle 220 No				
		- Accu Check 230. No				
	_	ented; should have				
		Next available Accu				
	Check 7/8/11 9:0	00 P.M 282.				
	7/14/11 6:00 D N	1 Accu Check 332. No				
	_	ented; should have				
		Next available Accu				
	Check 7/14/11 9:	:00 P.M 266.				
	7/14/11 0:00 D N	1 Accu Check 266. No				
	_	ented; should have Next available Accu				
	Check 7/15/11 6:	.uu A.ivi 94.				
	 7/15/11 12:00 ₽∃	M Accu Check 198.				
		rumented; should have				
	_	Next available Accu				
	Check 7/15/11 6:					
	Check //15/11 6:	.UU r.IVI 21/.				
	 7/16/11 9⋅00 ₽ №	1 Accu Check 181. No				
		ented; should have				
	_	Next available Accu				
	Check 7/17/11 6:					
	Cneck //1//11 6:	.UU A.IVI 102.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		INSTRUCTION 00	(X3) DATE S COMPL		
		155752	B. WING			09/15/2	011
	PROVIDER OR SUPPLIER		•	18325 E	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE I BEND, IN46637		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC DENTIFICAND DEFORMATIONS	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	7/17/11 6:00 P.M. Given 10 units; s units. Next avail 9:00 P.M 235. 7/19/11 6:00 P.M. Check 284. No c should have rece available Accu C 86. 7/20/11 9:00 P.M. Given 8 units; sh units. Next avail 6:00 A.M 79. Review of the Au Monitoring Flow incorrect sliding following eight A 8/1/11 9:00 P.M. Given 10 units; s units. Next avail 6:00 A.M 96. 8/8/11 9:00 P.M. Given 8 units; sh units. Next avail 6:00 A.M 96. 8/8/11 9:00 P.M. Given 8 units; sh units. Next avail 6:00 A.M 102.	I Accu Check 347. hould have received 8 able Accu Check 7/17/11 I. sic (9:00 P.M.) - Accu coverage documented; ived 6 units. Next heck 7/20/11 6:00 A.M I Accu Check 264. ould have received 6 able Accu Check 7/21/11 Ingust, 2011, "Diabetic Sheet", indicated scale coverage for the accu Checks: - Accu Check 343. hould have received 8 able Accu Check 8/2/11 - Accu Check 358. ould have received 10 able Accu Check 8/9/11 - Accu Check 292. No ented; should have Next available Accu		TAG	DEFICIENCY		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155752	B. WIN			09/15/2	011	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1		
NAME OF I	PROVIDER OR SUPPLIER			18325 E	BAILEY AVE			
	GSIDE NURSING A	AND MEMORY CARE CENTER		SOUTH	BEND, IN46637			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE	
	Check 8/10/11 6:00 A.M 94.							
	coverage documer received 8 units. Check 8/16/11 6: 8/20/11 12:00 P.I. Given 6 units; shunits. Next avail 6:00 P.M 254. 8/22/11 12:00 P.I. Given 2 units; shunits. Next avail 6:00 P.M 279. 8/30/11 9:00 P.M. Given 6 units; shunits; s	M Accu Check 245. could have received 4 lable Accu Check 8/20/11						
	11th, 2011, "Dial Sheet", indicated coverage for the 9/3/11 9:00 P.M. Given 10 units; s	eptember 1st through betic Monitoring Flow l incorrect sliding scale following Accu Check: - Accu Check 345. should have received 8 lable Accu Check 9/4/11						
	Resident # 40's c indicated, "Adı	are plan, dated 7/12/11, minister meds as						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
		155752	A. BUILDING B. WING		09/15/2011		
	ROVIDER OR SUPPLIER GSIDE NURSING A		STREET 18325	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE H BEND, IN46637			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE		
1710	ordered"	ESC IDENTIFICATION OR MITTERS	1110		Ditte		
	9/15/11 at 11:05 is now aware of the errors. She further the blood sugar in completeness but do age given becomer should know scale. A facility policy, provided by the Ind.M., indicated,	with the DON on A.M., she indicated she the multiple sliding scale ter indicated she checked monitoring tool for a not accuracy of the tause she assumed every w how to do sliding untitled, undated, DON on 9/15/11 at 11:00 "The resident is on the					
	be determined by	ne resident's dosage will blood glucose lered by the physician.					
F0514 SS=D	each resident in ac professional stand complete; accurate accessible; and sy The clinical record information to iden the resident's asse and services provi	naintain clinical records on ecordance with accepted ards and practices that are ely documented; readily estematically organized. must contain sufficient tiffy the resident; a record of essments; the plan of care ded; the results of any ening conducted by the					
	Based on intervie facility failed to e	ew and record review, the ensure the resident's as accurate, complete,	F0514	F514 – The facility will mainta clinical records in accordance with accepted professional standards. Nurses identified	e		

l i		(X2) M	ULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155752	B. WIN			09/15/2011	
NAME OF I	AD OUTDED ON GUIDNI TED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIER			18325 E	BAILEY AVE		
		AND MEMORY CARE CENTER		SOUTH	I BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	,	DATE	
	_	of 10 residents whose			have problems with documentation or legibility ha	ave.	
		vere reviewed in a sample			been disciplined. Resident #	I	
	of 10.				and #40 have had a review of		
					records to ensure legibility a	I	
	Resident # 26, #	40			accuracy in administration of	:	
					blood sugars. All resident		
	Findings include	:			records have been reviewed ensure compliance with clinic	I	
					records policy. In-services h	I	
	1. The clinical re	ecord for Resident # 26,		been completed with applicable			
	reviewed on 9/14/11 at 9:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and				staff. All diabetic flow sheet		
					entries, signatures,		
					documentation and signature	es in	
	dementia.	, hypertension, and			the nurses' notes is to be accurate, complete and		
	dementia.				l at		
		1 . 12/22/11					
		er, dated 3/23/11,			leat daily by DON or designee. Results of audits v	vill be	
	•	cu Check (blood sugar			reported to QA to ensure		
	test) before meal	s and at bedtime"			continued compliance.		
					Audits will be conducted daily	• • • • • • • • • • • • • • • • • • •	
	Review of the Ju	ne, 2011, "Diabetic			the first 3 months by Director Nursing or designee. The QA	01	
	Monitoring Flow	Sheet", indicated			committee will review findings	s to	
	incorrect sliding	scale coverage for the			determine if audits can be		
	following four A	-			suspended. If consistent compl	iance	
					is met for quarter. Than audit		
	6/17/11 6·00 A N	I Accu Check 479. No			will be performed once a wee	·	
		ented; should have			Director of Nursing or designe	e.	
	received 12 units						
	10001700 12 uiits	•					
	Review of the In	ly, 2011, "Diabetic					
	Monitoring Flow	-					
		f the amount of coverage					
	-	owing three Accu					
	Checks:						
	7/7/11 9:00 P.M.	- Accu Check both 372	\perp				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED					
		155752	B. WING	·		09/15/2	011
NAME OF I	PROVIDER OR SUPPLIEF	<u>.</u> {	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	•	
MORNIN	IGSIDE NURSING A	AND MEMORY CARE CENTER			BAILEY AVE I BEND, IN46637		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710	<u> </u>	ted. No coverage	-	1710			DATE
	documented.						
	7/12/11 9:00 P.N	M Accu Check 316. No					
	coverage docum	ented.					
	7/14/11 6:00 P.N	A Accu Check 337. No					
	coverage docum	ented.					
	Review of the August, 2011, "Diabetic Monitoring Flow Sheet", a lack of testing one time and lacked documentation of the amount of coverage given for the following one Accu						
	Check:						
	8/7/11 6:00 A.M	- No testing					
	documented.	. Two testing					
		M Accu Check 324.					
	No coverage doc						
	Review of Resid	lent # 26's care plan, dated					
	12/23/10, indica	ted, "11. Accu Check					
	as ordered by M	D"					
	During interview	w with the DON on					
	1	A.M., she indicated she					
	is now aware of						
		nd/or lack of testing. She					
		she checks the blood					
	sugar monitoring	g tool for completeness.					
	2. The clinical r	ecord for Resident # 40,					
		4/11 at 11:30 A.M.,					
		ses of, but not limited to:					
	1	s, hyperthyroidism, and					

PROVIDER OR SUPPLIER	155752	B. WING		
PROVIDER OR SUPPLIER				09/15/2011
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE NURSING AND MEMORY CARE CENTER			ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE	
			I BEND, IN46637	
	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
`		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE DATE
peripheral neuron	oathy.			
r · r · · · · · · · · · · · · · · · · ·	y .			
indicated, "Acc test) AC (before 1 (bedtime)"	u Check (blood sugar meals) & HS ly, 2011, "Diabetic			
Check testing for sugars and lacked	the following two blood documentation of the			
amount of coverage given for the following six Accu Checks and one illegible entry:				
documented. 7/8/11 6:00 P.M. coverage docume 7/14/11 6:00 P.M coverage docume 7/14/11 9:00 P.M coverage docume 7/15/11 12:00 P.M No coverage docume 7/16/11 9:00 P.M coverage docume 7/19/11 6:00 P.M coverage docume 7/20/11 6:00 A.M documented.	- Accu Check 230. No ented. Accu Check 332. No ented. Accu Check 266. No ented. M Accu Check 198. umented. Accu Check 181. No ented. Accu Check 284. No ented. I Accu Check 284. No ented. I No testing			
	peripheral neuropada Physician Order indicated, "Accitest) AC (before indicated, "Accitest) AC (before indicated, "Accitest) AC (before indicated, "Accitest) AC (before indicated, "Button of the Juli Monitoring Flow Check testing for sugars and lacked amount of coverate following six Accillegible entry: 7/4/11 6:00 A.M. documented. 7/8/11 6:00 P.M. coverage documented of the Juli Physician of the J	Review of the July, 2011, "Diabetic Monitoring Flow Sheet", lacked Accu Check testing for the following two blood sugars and lacked documentation of the amount of coverage given for the following six Accu Checks and one illegible entry: 7/4/11 6:00 A.M No testing documented. 7/8/11 6:00 P.M Accu Check 230. No coverage documented. 7/14/11 6:00 P.M Accu Check 332. No coverage documented. 7/14/11 9:00 P.M Accu Check 266. No coverage documented. 7/15/11 12:00 P.M Accu Check 198. No coverage documented. 7/16/11 9:00 P.M Accu Check 181. No coverage documented. 7/19/11 6:00 P.M Accu Check 284. No coverage documented. 7/20/11 6:00 A.M No testing documented. 7/24/11 No time documented (4:00 P.M.)	peripheral neuropathy. A Physician Order, dated 5/27/11, indicated, "Accu Check (blood sugar test) AC (before meals) & HS (bedtime)" Review of the July, 2011, "Diabetic Monitoring Flow Sheet", lacked Accu Check testing for the following two blood sugars and lacked documentation of the amount of coverage given for the following six Accu Checks and one illegible entry: 7/4/11 6:00 A.M No testing documented. 7/8/11 6:00 P.M Accu Check 230. No coverage documented. 7/14/11 6:00 P.M Accu Check 332. No coverage documented. 7/14/11 9:00 P.M Accu Check 266. No coverage documented. 7/15/11 12:00 P.M Accu Check 198. No coverage documented. 7/16/11 9:00 P.M Accu Check 181. No coverage documented. 7/19/11 6:00 P.M Accu Check 284. No coverage documented. 7/19/11 6:00 A.M No testing documented. 7/20/11 6:00 A.M No testing documented. 7/24/11 No time documented (4:00 P.M.)	peripheral neuropathy. A Physician Order, dated 5/27/11, indicated, "Accu Check (blood sugar test) AC (before meals) & HS (bedtime)" Review of the July, 2011, "Diabetic Monitoring Flow Sheet", lacked Accu Check testing for the following two blood sugars and lacked documentation of the amount of coverage given for the following six Accu Checks and one illegible entry: 7/4/11 6:00 A.M No testing documented. 7/8/11 6:00 P.M Accu Check 230. No coverage documented. 7/14/11 9:00 P.M Accu Check 332. No coverage documented. 7/14/11 9:00 P.M Accu Check 266. No coverage documented. 7/15/11 12:00 P.M Accu Check 198. No coverage documented. 7/16/11 9:00 P.M Accu Check 181. No coverage documented. 7/19/11 6:00 P.M Accu Check 284. No coverage documented. 7/19/11 6:00 P.M Accu Check 284. No coverage documented. 7/20/11 6:00 A.M No testing documented.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155752	B. WIN			09/15/20	011
NAME OF I	DROVIDED OD SLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF F	PROVIDER OR SUPPLIER			18325 E	BAILEY AVE		
		AND MEMORY CARE CENTER			H BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	bei relevel)		DATE
	Review of the August, 2011, "Diabetic						
		Sheet", lacked Accu					
		r the following five blood					
	_	d documentation of the					
	amount of covera						
	I -	ccu Checks and three					
	illegible entries: 8/7/11 6:00 A.M No testing documented. 8/9/11 12:00 P.M No testing						
	documented.						
		- Accu Check 292. No					
	coverage docume						
	8/9/11 9:00 P.M.						
	documented.	- No testing					
		A Ch1- 249					
		1 Accu Check 248.					
	Illegible entry.	6 A CL 1 220 N					
		1 Accu Check 338. No					
	coverage docume						
	8/17/11 6:00 P.M	1 No testing					
	documented.						
	8/17/11 9:00 P.M	I No testing					
	documented.						
		1 Illegible entry.					
	8/30/11 9:00 P.M	I Illegible entry.					
	Resident # 40's c	eare plan, dated 7/12/11,					
		nitor BS (blood sugar) as					
	ordered"	mior Do (orood sugar) as					
	ordered						
	Interview on 9/14	4/11 at 12:05 P.M., LPN					
	# 5 indicated she	was unable to read the					
	amount of covera	age given for the 8/11/11,					
		7			!	!	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
155752		A. BUILDING	. BUILDING 09/15/2011				
			B. WING	PEET AD	DRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				AILEY AVE		
		AND MEMORY CARE CENTER			BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAC	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
1110		sugar. She further	1710				DATE
		not sure who did it					
	because no one s						
	o country in one of	-8vu .v.					
	During interview	with the DON on					
	9/15/11 at 11:05	A.M., she indicated she					
	is now aware of t	the missing					
	documentation as	nd/or lack of testing. She					
	further indicated	she checks the blood					
	sugar monitoring	tool for completeness.					
	On 9/15/11 at 11:						
		dicated that some of the					
	clinical record en	ntries were unreadable.					
	3.1-50(a)(1)						
	3.1-50(a)(2)						
F0516 SS=B	A facility may not r resident-identifiabl	release information that is le to the public.					
	resident-identifiabl accordance with a agent agrees not t	elease information that is le to an agent only in contract under which the o use or disclose the to the extent the facility o do so.					
	information agains unauthorized use.	afeguard clinical record at loss, destruction, or					
		ation and interview, the	F0516		F516 – The facility will ensure		10/03/2011
	-	ensure unlicensed staff			unlicensed staff members do not have access to closed resident		
		ess to closed resident			records and that records are		
		records found in			maintained in a safe, secure environments. All inactive		
	uniocked drawers	s. This deficiency has the			resident files prior to 2011 ha	ve	

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	ETED
		155752	B. WIN			09/15/20)11
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEF	₹		18325 E	BAILEY AVE		
	IGSIDE NURSING	AND MEMORY CARE CENTER		SOUTH BEND, IN46637			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG		Na	DATE
	1 ^	et of the 58 of 58 of			been sent to offsite storage. records will be maintained in		
		records that were stored			shed. All records have been	I .	
	in those drawers	•			removed from this location.		
					Current residents records are	e	
	Findings include:				maintained in the facility in lo	cked	
					fireproof cabinets. Medical		
	During an obser	vation on 9/14/11 at 2:50			Records personnel will ensure that files are maintained in a		
	p.m., Medical Records Employee # 15 entered the office and opened a closet				secure environment. Audit of	I .	
					files will be conducted by		
	with louvered doors to retrieve some				Administrator or designee at		
	closed records. Three closed records were				monthly to ensure continued		
	observed sitting on the cabinets. Inside				compliance. Results of audi be reported to the QA team t		
	the closet was one sprinkler head, and in				ensure continued compliance		
	the office were t				Audits of files will be conduc		
	the office were t	wo more.			by Administrator or designee	once	
	During on intern	iov. on 0/14/11 at 2:50			a month. Results of audits wi	I .	
	1 -	iew on 9/14/11 at 2:50			reported every 3 months to Q		
	l -	edical Records Employee			committee. The QA committee will review findings to determ		
	1	ed that the closed records			additional audits need to be p		
	1 -	pinet were recently closed			place		
		e not been put away. She			•		
		at those records would					
	not be protected	against fire or water.					
	During an observ	vation on 9/14/11 at 2:55					
	p.m. with the Co	orporate Administrator					
	1 ^	cords Employee #15, the					
	1	vere observed kept behind					
	1	arge, two story wood shed					
	1	ling cabinets along with					
	1 -	tems for the building,					
	1	supplies, dirty laundry to					
	1						
	1	orations, etc. The shed					
	1	ked with the key kept in					
	I the key box mou	inted just above the door	1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			I i				(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE		
		155752	B. WIN			09/15/20)11	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				1	BAILEY AVE			
MORNIN	GSIDE NURSING A	ND MEMORY CARE CENTER		SOUTH	I BEND, IN46637			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE	
	handle. The Activities Director and Receptionist #16 were inside the shed							
	_							
		es. All medical records						
		ge locked metal file						
		foot tall filing cabinet						
		te the two of four drawers						
		sily opened. Each drawer						
	contained 29 bus							
	included the facesheets, date of birth,							
	social security numbers, addresses, and insurance information.							
	During on intervi	iew with the Corporate						
		the time, he indicated the						
		*						
	1	locked during the day.						
		I that the closed records						
		unlocked drawers would						
	1 -	from unauthorized						
	personnel or the	general public.						
	During an observ	vation on 9/15/11 at 10:05						
	~	shed behind the facility						
	· ·	closed records was found						
		e Environmental tour.						
		Maintenance Supervisor						
		de the key box above the						
	l -	the lock. The drawers						
	_	were found unlocked.						
	mentioned above	word roung universed.						
	During an intervi	iew on 9/15/11 at 10:05						
		intenance Supervisor, he						
		had many duplicate keys						
		ey get lost often. He also						
		key is over the lock to						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 09/15/2	ETED
MORNIN		AND MEMORY CARE CENTER		18325 E	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE I BEND, IN46637		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	supplies as needed Supervisor indicated drawers were un indicated the key prevent unauthor general public fr	to access the shed for ed. The Maintenance ated he was unaware the locked. When asked he over the lock would not rized personnel and the om accessing the two is with closed records.					